STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN46516

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F0000	This visit was for the Investigation of Complaint IN00093903. Complaint IN00093903- Substantiated. Federal/state deficiencies related to the allegations are cited at F323 Unrelated deficiency cited. Survey dates: 7/25-26/11 Facility number: 003075 Provider number: 155695 AIM number: 200364160 Survey team: Ellen Ruppel, RN-TC Carol Miller, RN Census bed type: SNF/NF: 89 Total: 89 Census payor type: Medicare: 7 Medicaid: 67 Other: 15 Total : 89 Sample: 6	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 08/25/2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 28, 2011 by Bev Faulkner, RN			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interviews and record review, the facility failed to ensure supervision and use of assistive devices (gait belts and locking wheelchairs) to prevent falls were provided for 2 of 6 residents who were identified as fall risks. Residents B and F Findings include: The closed clinical record of Resident B was reviewed, on 7/25/11 at 9:30 a.m., and indicated the resident had been admitted to the facility 11/24/10. Her diagnoses included, but were not limited to: dementia, bipolar disorder, and depression. She had originally been admitted to the facility's secure unit and them moved to the general population in	F0323	**F 323 – Accidentis and Supervision** **Whati corrective actior(s) will be accomplished fior tihose residentis fiound tio have been afiectied by tihis deficienti practice?** Itt is tthe practtce oft tthis provider tto ensure tthatt tthe residentt environmentt remains as ftree oft accidentt hazards as is possible and each residentt receives adequatte supervision and assisttance devices tto preventt accidentts **Whati corrective actior(s) will be accomplished fior tihose residentis fiound tio have been afiectied by tihe deficienti practice?** ***Resident B*** has been discharged ftrom tthe ftacilitty ***Resident F*** experienced no negattve outtcome as a resultt oft tthis ftnding This residentt has had no recentt ftalls All ftall preventton intterventtons and	08/25/2011

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	May of 2011. A fall risk assessment and subsequent care plan, dated 12/7/10, indicated Resident B was at risk of falls due to previous falls, an unsteady gait and the use of antidepressants and antipsychotic medications. The interventions for fall prevention included, but were not limited to: initiated on 12/7/10: non skid footwear, personal items in reach, environmental safety changes PRN (as needed), pharmacist to review meds routinely as possible causative factor and therapy screen quarterly and PRN. Interdisciplinary notes, dated 3/12/11 with no time specified, indicated the resident had sustained a fall with a fracture of the left humerus (arm) while ambulating in the hallway. The care plan was updated, on 3/12/11, to indicate the provision of assistance with transfers, ambulation and additional support as needed. The care plan was again updated on 5/9/11 following an incident when the resident had been lowered to the floor by two aides during a transfer on 5/7/11. The fall circumstance report, dated 5/7/11 at 16:30 (4:30 p.m.), indicated the aides had not locked the wheels on the wheelchair and were not using a gait belt when doing the transfer.		ttransfter needs have been communicatted tto caregivers.Two sttaft members witth use oft a gaitt beltt is being used ftor all ttransfters **How otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice will be identified and whati corrective action(s) will be tiaken?** All residentts identtfted as being att risk ftor ftalls have tthe pottenttal tto be aftectted by tthis ftnding and will be identtfted tthrough a ftacilitty auditt This auditt will include completton oft a new Fall Risk Assessmentt ftor each residentt Any residentt identtfted as being att risk ftor ftalls will tthen have ttheir ftalls care plan reviewed and updatted tto accurattely reftectt ttheir currentt sttattus and ttransfter needs including use oft alarms,proper placementt oft wheelchair cushions and gaitt beltts.The Residentt Care Sheetts will tthen be correctted/updatted tto reftectt tthese identtfted needs. Updattes and revisions tto care plans will be communicatted tto all caregivers.The Nurse Managementt Team will be responsible ftor completton oft tthis auditt. **Whati measures will be puti intio place or whati systiem changes will be made tio ensure tihati tihe deficienti practice does noti recur?** All nursing sttaft will be inserviced on 8/16/11. This in-service will be conductted by DNS and/or designee and will include review oft tthe ftacilitty	

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	Resident B sustained another fall, on 7/15/11 at 8:30 p.m., resulting in a fracture of the right femoral neck (hip). The fall report indicated the resident had attempted to get out of her wheelchair without assistance and staff members heard her wheelchair alarm sounding. Nurses notes, dated 7/15/11 at 8:30 p.m., indicated she initially complained about pain in the right leg and an x-ray of the right knee returned negative. Nurses notes, on 7/16/11 and 7/17/11, indicated she was not complaining of any pain. Nurses notes at 4:00 p.m., on 7/18/11 indicated she had begun to complain of severe pain in the right hip area and the physician ordered her sent to the hospital, where the fractured femoral head of the femur was diagnosed. Physician's orders, dated 5/31/11, (no time specified) indicated the clip alarm was to be discontinued when Resident B was up in the wheelchair and shelf liner (non skid material) was to be placed under the cushion in the wheelchair. During an interview with the Director of Nursing, on 7/25/11 at 2:00 p.m., about the placement of the non-slip material under the cushion in the wheelchair, she indicated it was to keep the cushion from slipping. The DON also indicated the clip		policy ttttled "Fall Managementt Program". This in-service will also include review oft ftall preventtqn ftollowing esttablished care plan intterventtons, proper use oft gaitt beltts ftor ttransfte,s proper use oft wheelchair and bed alarms as well as appropriatte placementt oft wheelchair cushions. Fall Risk Assessmentts are completted on admission, annually, quartterly and witth any signiftcantt change in conditton. All ftalls will conttnue tto be reviewed in tthe IDT Meettng daily. Fall care plans will be reviewed and updatted att tthatt ttme Any changes, new intterventtons or updattes tto tthe care plan and Residentt Care Sheett will be communicatted tto all caregivers att tthatt ttme **How tihe corrective actior(s) will be monitiored tio ensure tihe deficienti practice will noti recur, i.e., whati qualitiy assurance program will be intio place?** To ensure compliance witth tthis correcttve actton, tthe DNS and/or designee will be responsible ftor completton oft tthe CQI Auditt ttool ttttled,"Fall Managementt Program" weekly x 4 weeks and montthly tthereafter. In additton, compliance witth tthe use oft residentt speciftc assisttve devices will be monittored tthrough routtne rounds and observatton. Findings will be reportted tto tthe CQI committee ftor review and correcttve actton ift	

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	alarm had been added again as a nursing measure to help prevent falls. The therapy supervisor was interviewed, on 7/26/11 at 9:00 a.m., about the placement of the non-slip material on wheelchair seats and she indicated it belonged on top of the cushions, rather than beneath them. The packaging material was observed, in the therapy department, on 7/26/11, and no specific instructions were on the container. The therapist indicated she had seen Resident B's non-slip material on top of the wheelchair cushion the week prior to the 7/15/11 fall. Review of the undated facility policy regarding gait belt use, provided by the Administrator, on 7/26/11 at 9:00 a.m., indicated: "Gait belts are to be used at all times for transfers or mobility with the exception of recent surgical sites in the abdominal area. Colostomy sites, cardiac precautions, or hiatal hernias (sic). Gait belts are to be applied over clothing, not bare skin. Gait belts are to be positioned around the lower waist or hips, avoiding ribs, breasts, or bony areas where bruising the skin could occur....4. Any staff found not using gait belts as directed will result in disciplinary action up to and including termination."		needed. **By whati datie tihe systiemic changes will be completied?** Compliance Datte 8/25/11.	

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	LPN (licensed practical nurse) #6 was queried on 7/25/11 at 2:40 p.m., about disciplinary actions for the two aides who had not locked the wheels on Resident B's wheelchair or used a gait belt. LPN #6 indicated she had not disciplined the two aides, but had "talked" to them. Prior to an observation of the transfer of dependent Resident F, on 7/25/11 at 1:20 p.m., CNA #4 was queried about using a gait belt and she responded she had left her gait belt in the car. She was then observed obtaining one from the closest nurses desk and then with the assistance of the Director of Nursing, transferred the resident from the wheelchair to the toilet and then back into the wheelchair and to a recliner in the resident's room. The resident was queried about the use of gait belts during her transfers and she responded, "No, they don't always use one, but they should." The aide assignment sheet indicated a gait belt was to be used with all transfers and the most MDS (minimum data set) assessment, of 6/14/11, indicated she was in need of the total assistance of 2 staff members for transfers. This federal tag relates to Complaint In00093903. 3.1-45(a)(2)			

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F9999	STATE RULE FINDINGS 3.1-13 ADMINISTRATION AND MANAGEMENT. (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents This state rule was not met as evidenced by:	F9999	**F9999 State Rule Findings – Administration and Management** It is the practice of this provider to inform the division and other agencies within 24 hours of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident C was*** re-admitted to the facility, 8/5/11, after an in-patient psychiatric stay. Her needs will be assessed and appropriate interventions will be put into place for her safety and communicated to all caregivers. Any staff members involved in this incident have been re-educated by the Director of Operation on the facility policy regarding timely reporting of unusual occurrences.**How other residents having the potential to be affected by the same**	08/25/2011

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	Based on observation, interviews and record review, the facility failed to inform the division when 1 of 2 residents identified as elopement risks, in a sample of 6, eloped from the facility. Resident C Findings include: Resident C entered the conference room on 7/26/11 at 10:00 a.m., and indicated she wanted to be interviewed regarding an issue which concerned her. She indicated she wanted some morphine for a headache and "a couple of days ago" had kicked the front glass door open to go to the local emergency room. She then pointed to her ankle and a wanderguard device was observed on her ankle. She indicated the alarm had "gone off" when she pushed the door the first time, but when she kicked it twice, it "flew open" and she was able to run out the door. She said the staff members were in "hot pursuit" and caught up with her "a block or so away" and went to the hospital emergency room with her. She said she then came back to the facility with staff members. The clinical record of Resident C was reviewed, on 7/26/11 at 10:20 a.m., and indicated she had been admitted to the facility on 7/6/11, with diagnoses including, but not limited to: anoxic brain syndrome.		**deficient practice will be identified and what corrective action(s) will be taken?** Any resident identified as being at risk for elopement has the potential to be affected by this finding.Any incident of resident elopement will be reported immediately to the Administrator and DNS. The facility will immediately initiate the "Elopement/Missing Resident Procedure" as well as ensure notification to the MD, family, ISDH, and other agencies as outlined in the facility policy. Elopement Risk Assessments are completed on all residents on admission, annually, quarterly and with any significant change in condition. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An all staff in-service will be held on 8/16/11. This in-service will be conducted by the DNS and/or designee and will include review of the facility policy and procedure titled "Missing Resident/Resident Elopement" as well as facility policy titled, "Unusual Occurrences for Residents and Visitors". All staff will be reminded of the importance of immediate notification to the Administrator, DNS, MD, family, ISDH and other agencies as outlined in the facility policy. **How will the corrective action(s) be monitored to**	

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	An elopement risk assessment, dated 7/10/11, indicated she was at risk for elopement and a security bracelet had been applied. Social service notes, dated 7/22/11 at 3:30 p.m., indicated the resident was exhibiting verbal aggression and paranoid ideation and had called the fire department. The note indicated the facility was attempting to have her admitted to the local psychiatric unit without success. The note indicated, "Res. (resident) con't (continues) to fixate on wanting to go to baseball game in (local city) when we informed res that she would have to have a family member escort-res became uncontrollable pounding her hands on nsg (nursing) station-(unreadable word)\screaming- stating she will leave this place & (and) never come back-she went to front doors-kicked open doors violently & began running down street-writer ran right behind her & never lost sight of where res. was @ (at) all times. Res ended walking into (local emergency room) asking to be helped by (physician's name) because we would not let her go to a baseball game. The police arrived to question self & resident. Got her into ER (emergency room) for observation & eval (evaluation) after she complained of chest pain--(psychiatric		**ensure the deficient practice will not recur, i.e. what Quality Assurance Program will be put into place?** The Administrator, DNS or other designee will be responsible for completion of the CQI Audit Tool titled, “Elopement Procedure/Training for Staff”. This tool will be completed monthly x3 and quarterly thereafter. In addition, the facility will conduct Elopement Drills monthly, with each shift participating quarterly. Finding will be reported to the CQI committee for review and corrective active if needed.All unusual occurrences will be reported to the appropriate agency within 24 hours Per facility policy.**By what date the systemic changes will be completed?** Compliance date: 8/25/11.	

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	unit) again notified of incident for possible inpatient stay--(psychiatric unit) would not eval (evaluate)- states there is nothing medically or psychologically wrong for admit. Psychiatrist states, 'she had a tantrum, that's it.' Res was sent back to facility via (local emergency transport)." The administrator was queried, on 7/26/11 at 10:45 a.m., about reporting the incident to the state survey agency and he indicated the incident had not been reported. The facility policy for reporting of unusual occurrences was provided by the administrator at 1:15 p.m., on 7/26/11. The most current review date on the policy was 10/01. The policy indicated any elopement which required police notification would be reported to the state survey agency. This had not been done. 3.1-13(g)(1)			